

SECTION

9

Medicare Advantage

Chart 9-1. MA plans available to virtually all Medicare beneficiaries

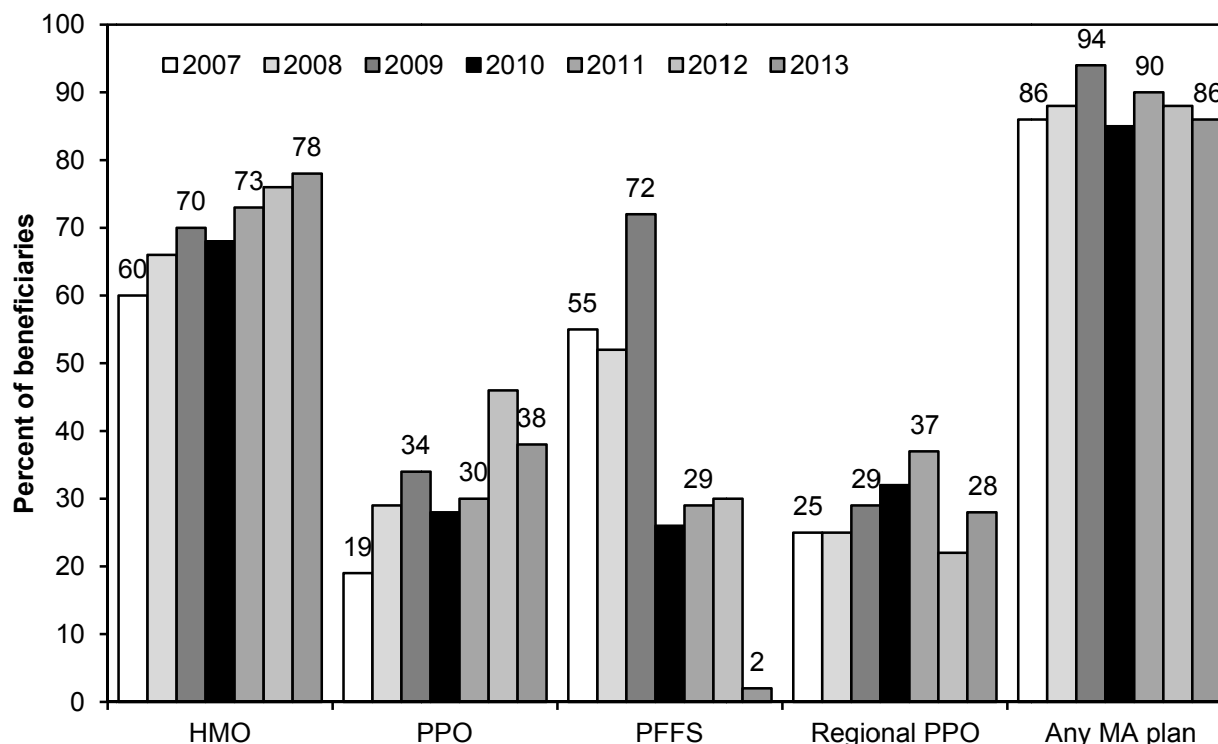
	CCPs			PFFS	Any MA plan	Average plan offerings per county
	HMO or local PPO	Regional PPO	Any CCP			
2005	67%	N/A	67%	45%	84%	5
2006	80	87	98	80	100	12
2007	82	87	99	100	100	20
2008	85	87	99	100	100	35
2009	88	91	99	100	100	34
2010	91	86	99	100	100	21
2011	92	86	99	63	100	12
2012	93	76	99	60	100	12
2013	95	71	99	59	100	12

Note: MA (Medicare Advantage), CCP (coordinated care plan), HMO (health maintenance organization), PPO (preferred provider organization), PFFS (private fee-for-service), N/A (not applicable). These data do not include plans that have restricted enrollment or are not paid based on the MA plan bidding process (special needs plans, cost-based plans, employer-only plans, and certain demonstration plans).

Source: MedPAC analysis of plan bid data from CMS.

- There are four types of MA plans, three of which are CCPs. Local CCPs include local PPOs and HMOs, which have comprehensive provider networks and limit or discourage use of out-of-network providers. Local CCPs may choose which individual counties to serve. Regional PPOs cover entire state-based regions and have networks that may be looser than those required of local PPOs. Since 2011, PFFS plans (not CCPs) are required to have networks in areas with two or more CCPs. In areas where there are not two or more CCPs, PFFS plans are not required to have networks and enrollees are free to use any Medicare provider.
- Local CCPs are available to 95 percent of Medicare beneficiaries in 2013—up from 67 percent in 2005. Regional PPOs are available to 71 percent of beneficiaries, down from 76 percent in 2012. The availability of MA PFFS plans has declined from 100 percent of beneficiaries in 2010 to 59 percent of beneficiaries in 2013. The decline is due to recent provider network requirements in most of the country. For the past eight years, virtually 100 percent of Medicare beneficiaries have had MA plans available, up from 84 percent in 2005.
- The number of plans from which beneficiaries may choose in 2013 is about the same as last year. In 2013, beneficiaries can choose from an average of 12 plans operating in their counties. This number has decreased after peaking in 2008 and 2009, reflecting CMS's 2010 effort to reduce the number of duplicative plans and plans with small enrollment as well as network requirements for PFFS plans.

Chart 9-2. Access to zero-premium plans with MA drug coverage, 2007–2013

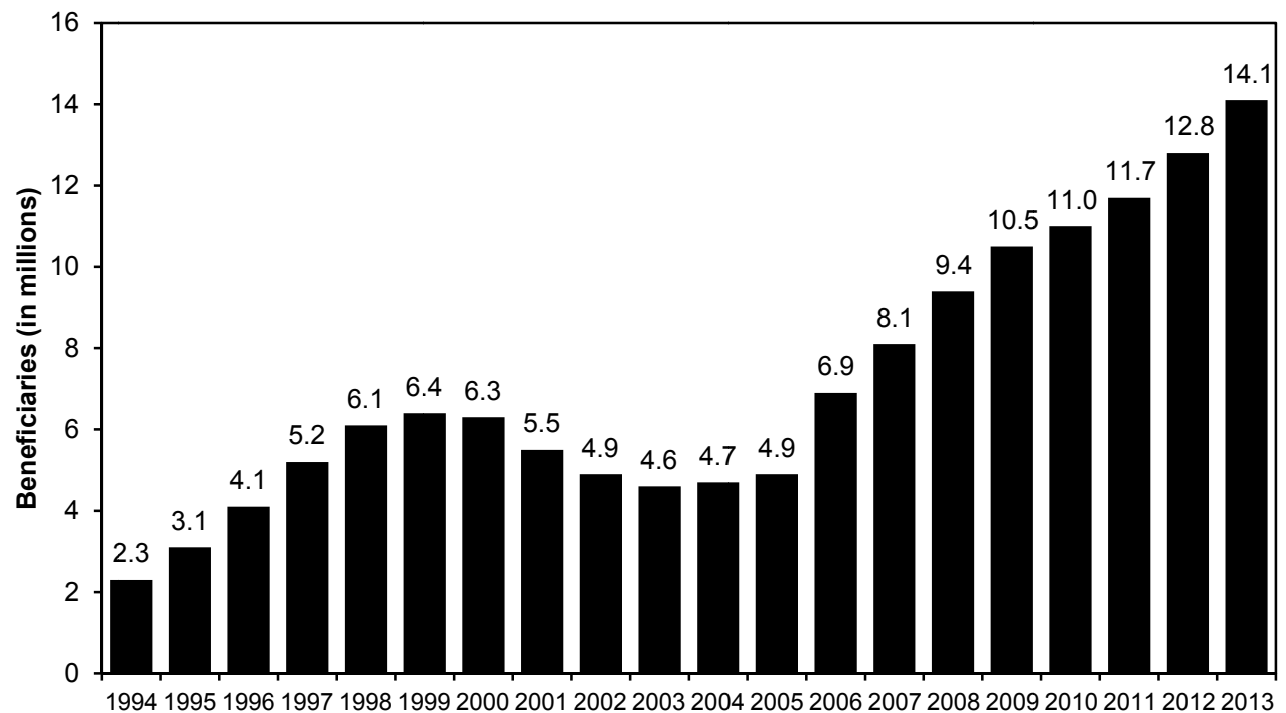


Note: MA (Medicare Advantage), HMO (health maintenance organization), PPO (preferred provider organization), PFFS (private fee-for-service).

Source: MedPAC analysis of bid and plan finder data from CMS.

- Across all plan types, the availability of zero-premium plans—plans with no beneficiary premium other than the Medicare Part B premium—has ranged from 85 percent to 94 percent since 2007. Most beneficiaries can obtain a Medicare Advantage–Prescription Drug (MA–PD) plan, an MA plan that includes Part D drug coverage, for which the enrollee pays no premium. In 2013, 86 percent of Medicare beneficiaries have access to at least one MA–PD plan with no premium (beyond the Medicare Part B premium) for the combined coverage (and no premium for any non-Medicare-covered benefits included in the benefit package), compared with 88 percent in 2012.
- Seventy-eight percent of beneficiaries have zero-premium MA–PD HMOs available. MA–PD PPOs without premiums are less widely available but are available to 38 percent of beneficiaries in 2013, while zero-premium regional PPOs are available to 28 percent of Medicare beneficiaries. PFFS plans offering zero premiums and Part D drug coverage are available to only 2 percent of beneficiaries in 2013, down from 30 percent of beneficiaries in 2012.
- In most cases, MA plan enrollees continue paying their Medicare Part B premium, but some MA–PD plans use rebate dollars to reduce or eliminate their enrollees’ Part B premium obligation.

Chart 9-3. Enrollment in MA plans, 1994–2013



Note: MA (Medicare Advantage).

Source: Medicare managed care contract reports and monthly summary reports, CMS.

- Medicare enrollment in MA plans paid on an at-risk capitated basis is at an all-time high at 14.1 million enrollees (28 percent of all Medicare beneficiaries). Enrollment rose rapidly throughout the 1990s, peaking at 6.4 million enrollees in 1999, and then declined to a low of 4.6 million enrollees in 2003. MA enrollment has increased steadily since 2003.

Chart 9-4. Changes in enrollment vary among major plan types

Plan type	Total enrollees (in thousands)				Percent change 2012–2013
	February 2010	February 2011	February 2012	February 2013	
Local CCPs	8,534	9,993	11,382	12,580	11%
Regional PPOs	760	1,132	930	1,060	14
PFFS	1,657	588	518	417	–19

Note: CCP (coordinated care plan), PPO (preferred provider organization), PFFS (private fee-for-service). Local CCPs include health maintenance organizations and local PPOs.

Source: CMS health plan monthly summary reports.

- Enrollment in local CCPs grew by 11 percent over the past year. Enrollment in regional PPOs grew by 14 percent after having contracted the previous year, while enrollment in PFFS plans continued to decline. Combined enrollment in the three types of plans grew by 10 percent from February 2012 to February 2013.

Chart 9-5. MA and cost plan enrollment by state and type of plan, 2013

State	Medicare eligibles (in thousands)	Distribution (in percent) of enrollees by plan type					Total
		HMO	Local PPO	Regional PPO	PFFS	Cost	
U.S. total	50,674	19%	6%	2%	1%	1%	29%
Alabama	902	14	7	2	0	0	23
Alaska	72	0	0	0	0	0	0
Arizona	1,006	35	2	1	1	0	39
Arkansas	563	8	3	3	5	0	18
California	5,140	36	1	0	0	0	38
Colorado	693	28	3	0	1	4	36
Connecticut	599	19	3	1	0	0	23
Delaware	162	5	2	0	0	0	7
Florida	3,611	26	2	9	0	0	37
Georgia	1,364	7	12	5	2	0	26
Hawaii	223	17	14	14	0	2	46
Idaho	251	9	20	0	1	0	31
Illinois	1,949	6	4	0	0	0	11
Indiana	1,072	2	13	5	1	0	21
Iowa	541	6	6	0	0	2	14
Kansas	457	5	6	0	2	0	13
Kentucky	811	3	13	6	1	1	23
Louisiana	734	23	1	2	1	0	27
Maine	285	10	7	0	0	0	18
Maryland	851	3	2	0	0	3	9
Massachusetts	1,132	15	2	1	0	0	18
Michigan	1,770	12	14	2	1	0	27
Minnesota	841	16	5	0	0	28	50
Mississippi	527	6	3	2	1	0	13
Missouri	1,064	16	5	2	2	0	25
Montana	183	0	12	0	4	0	15
Nebraska	293	6	3	0	3	1	13
Nevada	394	29	3	0	1	0	33
New Hampshire	239	1	2	0	2	0	5
New Jersey	1,409	14	1	0	0	0	16
New Mexico	339	19	10	0	1	0	29
New York	3,159	25	6	2	1	0	34
North Carolina	1,613	12	4	2	2	0	21
North Dakota	112	0	2	0	1	10	13
Ohio	2,015	16	16	4	0	1	38
Oklahoma	638	11	4	0	1	0	17
Oregon	674	22	21	0	0	0	43
Pennsylvania	2,397	23	15	0	1	0	39
Puerto Rico	709	66	6	0	0	0	72
Rhode Island	192	33	1	1	0	0	36
South Carolina	846	5	7	6	2	0	20
South Dakota	144	0	6	0	1	7	14
Tennessee	1,139	23	6	1	0	0	30
Texas	3,282	16	7	3	1	1	28
Utah	309	23	10	0	0	1	34
Vermont	121	0	1	1	5	0	7
Virgin Islands	9	1	0	0	-	0	1
Virginia	1,237	5	4	2	3	2	15
Washington	1,062	23	6	0	0	0	29
Washington, D.C.	83	2	2	0	0	7	11
West Virginia	399	2	8	10	2	3	24
Wisconsin	972	17	10	1	2	4	34
Wyoming	87	0	1	0	2	1	4

Note: MA (Medicare Advantage), HMO (health maintenance organization), PPO (preferred provider organization), PFFS (private fee-for-service). Cost plans are not MA plans; they submit cost reports rather than bids to CMS. Totals may not sum due to rounding.

Source: CMS enrollment and population data, 2013.

Chart 9-6. MA plan benchmarks, bids, and Medicare program payments relative to FFS spending, 2013

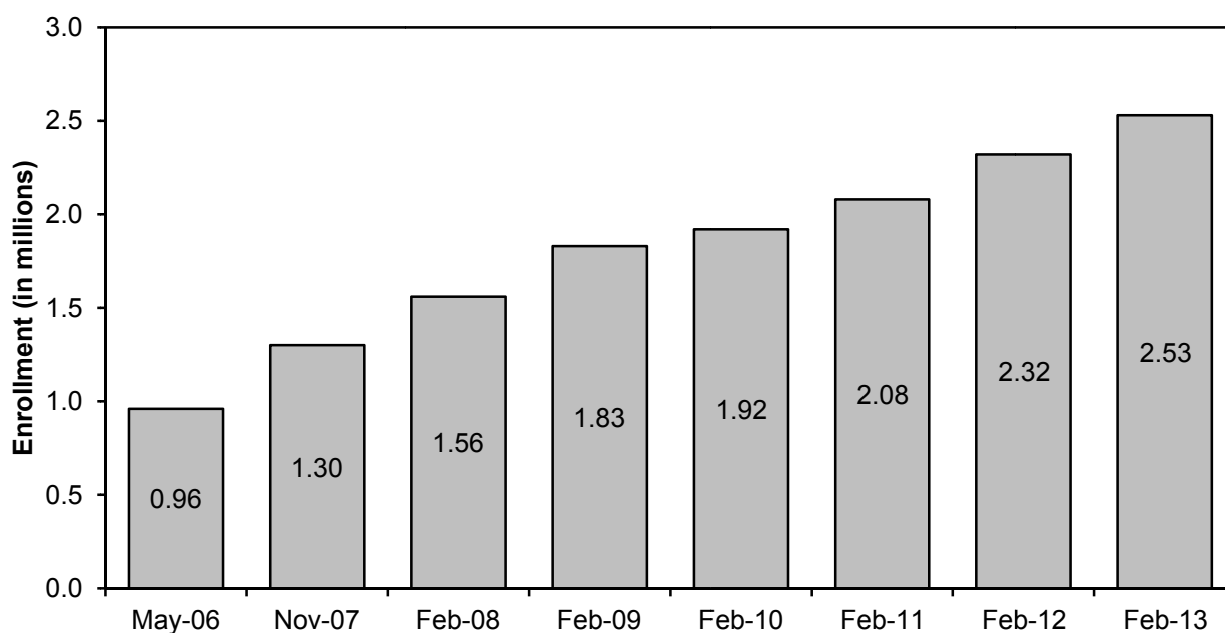
	All plans	HMOs	Local PPOs	Regional PPOs	PFFS
Benchmarks/FFS	110%	110%	111%	106%	110%
Bids/FFS	96	92	107	97	105
Payments/FFS	104	103	108	102	107

Note: MA (Medicare Advantage), FFS (fee-for-service), HMO (health maintenance organization), PPO (preferred provider organization), PFFS (private fee-for-service).

Source: MedPAC analysis of plan bid data from CMS, October 2012.

- Since 2006, plan bids have partially determined the Medicare payments they receive. Plans bid to offer Part A and Part B coverage to Medicare beneficiaries (Part D coverage is bid separately). The bid includes plan administrative cost and profit. CMS bases the Medicare payment for a private plan on the relationship between its bid and its applicable benchmark.
- The benchmark is an administratively determined bidding target. Legislation established the formula, being phased in by 2017, for calculating benchmarks in each county, based on percentages (ranging from 95% to 115%) of each county's per capita Medicare spending.
- If a plan's bid is above the benchmark, then the plan receives the benchmark as payment from Medicare, and enrollees have to pay an additional premium that equals the difference. If a plan's bid is below the benchmark, the plan receives its bid, plus a "rebate," defined by law as a percentage of the difference between the plan's bid and its benchmark. The percentage is based on the plan's quality rating and is phased in so that in 2014 it will range from 50 percent to 70 percent. (In 2011, all plan rebates were set at 75 percent.) The plan must then return the rebate to its enrollees in the form of supplemental benefits, lower cost sharing, or lower premiums.
- We estimate that MA benchmarks average 110 percent of FFS spending when weighted by MA enrollment. The ratio varies by plan type, because different types of plans tend to draw enrollment from different types of areas.
- Plans' enrollment-weighted bids average 96 percent of FFS spending. We estimate that HMOs bid an average of 92 percent of FFS spending, while bids from other plan types average at least 97 percent of FFS spending. These numbers suggest that HMOs can provide the same services for less than FFS in the areas where they bid, while most other plan types tend to charge more.
- We project that 2013 MA payments will be 104 percent of FFS spending. It is likely this number will decline over the next few years as benchmarks are gradually reduced relative to FFS levels to meet requirements under the Patient Protection and Affordable Care Act of 2010.
- The ratio of payments relative to FFS spending varies by the type of MA plan. HMOs and regional PPO payments are estimated to be 103 percent and 102 percent of FFS, respectively, while payments to PFFS and local PPOs will average 107 percent and 108 percent of FFS, respectively.

Chart 9-7. Enrollment in employer group MA plans, 2006–2013

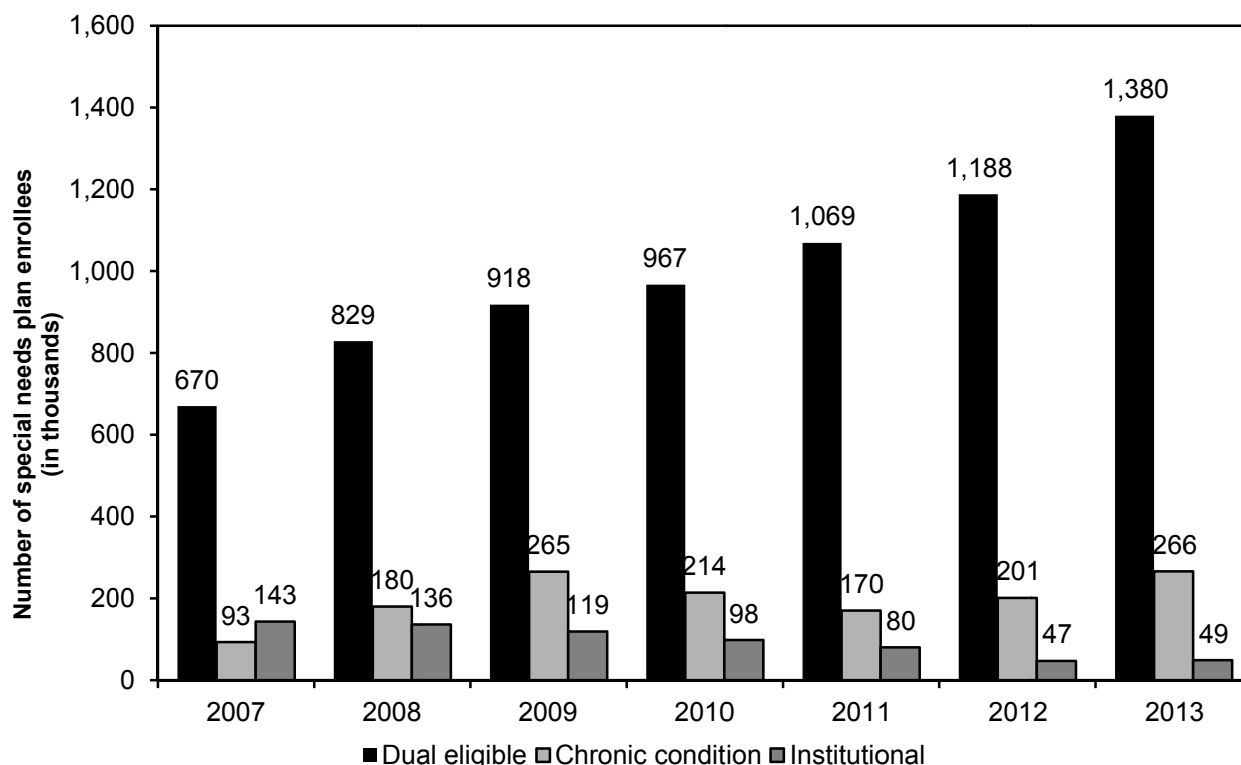


Note: MA (Medicare Advantage).

Source: CMS enrollment data.

- While most MA plans are available to any Medicare beneficiary residing in a given area, some MA plans are available only to retirees whose Medicare coverage is supplemented by their former employer or union. These plans are called employer group plans. Such plans are usually offered through insurers and are marketed to groups formed by employers or unions rather than to individual beneficiaries.
- As of February 2013, about 2.5 million enrollees were in employer group plans, or about 18 percent of all MA enrollees.
- Our analysis of MA bid data shows that employer group plans on average have bids that are higher relative to fee-for-service (FFS) spending than individual plans, meaning that group plans appear to be less efficient than individual market MA plans. Employer group plans bid an average of 106 percent of FFS, compared with 94 percent of FFS for individual plans (not shown in Chart 9-7).

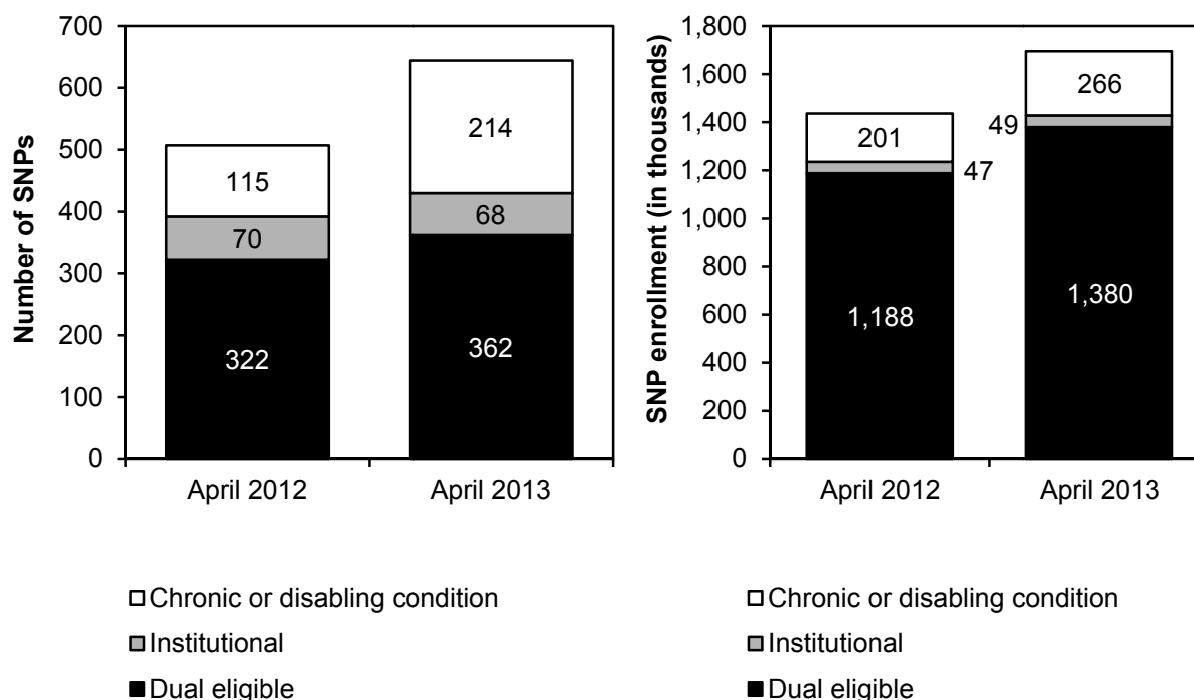
Chart 9-8. Number of special needs plan enrollees, 2007–2013



Source: CMS special needs plans comprehensive reports, May 2007, April 2008–2013.

- The Congress created special needs plans (SNPs) as a new Medicare Advantage (MA) plan type in the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 to provide a common framework for the existing plans serving special needs beneficiaries and to expand beneficiaries' access to and choice among MA plans.
- SNPs were originally authorized for five years. SNP authority was extended, subject to new requirements, by the Medicare, Medicaid, and SCHIP Extension Act of 2007; the Medicare Improvements for Patients and Providers Act of 2008; the Patient Protection and Affordable Care Act of 2010; and the Taxpayer Relief Act of 2012. Absent further congressional action, SNP authority will expire at the end of 2015.
- CMS approves three types of SNPs: dual eligible SNPs enroll only beneficiaries dually entitled to Medicare and Medicaid, chronic condition SNPs enroll only beneficiaries who have certain chronic or disabling conditions, and institutional SNPs enroll only beneficiaries who reside in institutions or are nursing home certified.
- Enrollment in dual eligible SNPs has grown continuously and is about 1.4 million in 2013.
- Enrollment in chronic condition SNPs has fluctuated as plan requirements have changed.
- Enrollment in institutional SNPs has declined steadily, although enrollment in 2013 is about the same as in 2012.

Chart 9-9. Number of SNPs and SNP enrollment rose from 2012 to 2013



Note: SNP (special needs plan).

Source: CMS special needs plans comprehensive reports, April 2012 and 2013.

- The number of SNPs increased by 27 percent from April 2012 to April 2013, and the number of SNP enrollees increased by 18 percent.
- In 2013, most SNPs (56 percent) are for dual-eligible beneficiaries, while 33 percent are for beneficiaries with chronic conditions, and 11 percent are for beneficiaries who reside in institutions (or reside in the community but have a similar level of need).
- Enrollment in SNPs has grown from 0.9 million in May 2007 (not shown) to 1.7 million in April 2013.
- The availability of SNPs has increased and varies by type of special needs population served. In 2013, 82 percent of beneficiaries reside in areas where SNPs serve dual-eligible beneficiaries (up from 78 percent in 2012), 46 percent live where SNPs serve institutionalized beneficiaries (up from 41 percent), and 56 percent live where SNPs serve beneficiaries with chronic conditions (up from 45 percent).

Chart 9-10. Twenty most common condition categories among MA beneficiaries, defined in the CMS–HCC model, 2011

Conditions (defined by HCC)	Percent of beneficiaries
Diabetes without complications	12.8%
Breast, prostate, colorectal, and other cancers	6.7
Diabetes with renal or peripheral circulatory manifestation	5.1
Diabetes with neurologic or other specified manifestation	3.4
CHF	2.9
Major depressive, bipolar, and paranoid disorders	2.8
Rheumatoid arthritis	2.6
Vascular disease	2.4
COPD	2.4
Specified heart arrhythmias	2.3
Angina pectoris/old myocardial infarction	1.6
Polyneuropathy	1.5
Diabetes with ophthalmologic or unspecified manifestation	1.5
Renal failure	1.4
Diabetes with renal or peripheral circulatory manifestation plus polyneuropathy	1.3
Diabetes with neurologic or other specified manifestation plus polyneuropathy	1.3
Lymphatic, head and neck, brain, and other major cancers	1.2
Breast, prostate, colorectal, and other cancers plus diabetes without complication	1.1
Diabetes without complication plus CHF	1.1
Septicemia/shock	1.0

Note: MA (Medicare Advantage), HCC (hierarchical condition category), CHF (congestive heart failure), COPD (chronic obstructive pulmonary disease).

Source: MedPAC analysis of Medicare data files from Acumen, LLC.

- CMS uses the CMS–hierarchical condition categories (CMS–HCC) model to risk adjust capitated payments to MA plans, so that payments better reflect the clinical needs of MA enrollees given the number and severity of their clinical conditions. The CMS–HCC model uses beneficiaries’ conditions that are collected into HCCs to adjust the capitated payments.
- The CMS–HCC model includes 70 HCCs, which represent a broad spectrum of conditions. Five of the 70 HCCs represent diabetes categories that vary by severity.
- The five diabetes HCCs are among 7 of the 20 most common HCC combinations. Other common conditions are CHF, mental disorders, and rheumatoid arthritis.

Chart 9-11. Medicare private plan enrollment patterns by age and Medicare–Medicaid dual-eligible status, January 2011

	As percent of Medicare population	Percent of category in FFS	Percent of category in plans
All beneficiaries	100%	75%	25%
Aged (65 or older)	83	73	27
Under 65	17	82	18
Non–dual eligible	82	74	26
Aged (65 or older)	72	73	27
Under 65	10	80	20
Dual eligible	18	81	19
Aged (65 or older)	11	77	23
Under 65	8	86	14
Dual-eligible beneficiaries by category (all ages)			
Full dual eligibility	14	84	16
Beneficiaries with partial dual eligibility			
QMB only	2	77	23
SLMB only	2	66	34
QI	1	61	39

Note: FFS (fee-for-service), QMB (qualified Medicare beneficiary), SLMB (specified low-income beneficiary), QI (qualified individual). Dual eligibles are beneficiaries eligible for Medicare and Medicaid. See accompanying text for an explanation of the categories of dual-eligible beneficiaries. Data exclude Puerto Rico because of the inability to determine specific dual-eligible categories. As of July 2011, dual-eligible special needs plans in Puerto Rico enrolled 239,000 beneficiaries. Plans include Medicare Advantage plans as well as cost-reimbursed plans. Percentages may not add to 100 due to rounding.

Source: MedPAC analysis of 2011 denominator file.

- Dual-eligible beneficiaries are more likely to receive their Medicare coverage through the traditional FFS program—81 percent of dual-eligible and 74 percent of non–dual-eligible beneficiaries are in FFS. However, recent levels of Medicare plan enrollment among the dually eligible represent a significant increase over earlier years. In 2004, only 1 percent of dual-eligible beneficiaries were enrolled in plans compared with 16 percent of non–dual-eligible beneficiaries.
- A substantial share of dual-eligible beneficiaries (42 percent) are under the age of 65 and therefore are entitled to Medicare on the basis of disability. Beneficiaries under age 65 are less likely than aged beneficiaries to enroll in Medicare plans (18 percent vs. 27 percent (not shown in chart)). Comparing dual-eligible beneficiaries under age 65 with non–dual eligibles under age 65 shows that the latter are more likely to be plan enrollees—14 percent and 20 percent, respectively.
- Dual-eligible beneficiaries who have full dual eligibility—that is, those who have coverage for their Medicare out-of-pocket costs (premiums and cost sharing) as well as coverage for services such as long-term care services and supports—are less likely to enroll in Medicare plans than beneficiaries with “partial” dual eligibility. Full dual-eligibility categories consist of beneficiaries with coverage through state Medicaid programs that include drug coverage as well as certain QMBs and SLMBs who also have Medicaid coverage for services. The latter two categories are referred to as QMB Plus and SLMB Plus beneficiaries. Beneficiaries with partial dual eligibility have coverage for Medicare premiums only (through the QI or SLMB program) or premiums and Medicare cost sharing, in the case of the QMB program. SLMB-only and QI beneficiaries have higher rates of plan enrollment (34 percent and 39 percent, respectively) than any other category shown in Chart 9-11, and it is higher than the average rate (25 percent) across all Medicare beneficiaries.

Chart 9-12. Distribution of MA plans and enrollment by CMS overall star ratings, February 2013

	Star rating: Number of stars							
Plans and enrollment	5	4.5	4	3.5	3	2.5	2	Any star rating
All plan types								
Number of plans	11	54	62	131	127	60	2	447
Enrollment (in thousands)	1,280	2,177	1,793	5,310	2,863	696	18	14,137
As percent in rated plans	9%	15%	13%	38%	20%	5%	0%	100%
HMOs								
Number of plans	11	39	40	80	79	48	1	298
Enrollment	1,280	1,586	1,271	3,123	1,804	542	4	9,610
As percent of HMO enrollees	13%	16%	13%	32%	19%	6%	0%	100%
Local PPOs								
Number of plans	0	14	22	45	35	8	N/A	124
Enrollment	0	568	522	1,529	346	87	N/A	3,051
As percent of local PPO enrollees	N/A	19%	17%	50%	11%	3%	N/A	100%
Regional PPOs								
Number of plans	0	1	0	2	8	0	0	11
Enrollment	N/A	24	N/A	439	598	N/A	N/A	1,060
As percent of regional PPO enrollees	N/A	2%	N/A	41%	56%	N/A	N/A	100%
PFFS								
Number of plans	0	0	0	4	5	4	1	14
Enrollment	0	0	0	219	115	68	14	416
As percent of PFFS enrollees	N/A	N/A		53%	28%	16%	3%	100%

Note: MA (Medicare Advantage), HMO (health maintenance organization), PPO (preferred provider organization), N/A (not available), PFFS (private fee-for-service). For purposes of this table, a plan is an MA contract, which can consist of several options with different benefit packages that are also referred to as "plans." Cost-reimbursed HMO plans are included in the data. Numbers may not add to 100 percent due to rounding; enrollment totals are rounded results of the sum of unrounded numbers.

Source: MedPAC analysis of CMS star ratings and enrollment data, 2013.

- The star rating system is a composite measure of clinical processes and outcomes, patient experience measures, and measures of a plan's administrative performance. The overall star rating measures performance on Part C measures and Part D measures.
- The average overall star rating across all plans is 3.44, or 3.70 on an enrollment-weighted basis. There are 126 plans, with 365,000 enrollees, that do not have a star rating because they are too new to be rated or there is insufficient information on which to base a rating.

(Chart continued next page)

Chart 9-12. Distribution of MA plans and enrollment by CMS overall star ratings, February 2013 (continued)

- Under a program-wide demonstration, beginning in 2012, plans with ratings of 3 stars or above receive bonus payments in the form of an increase in their benchmarks. Plan star ratings also determine the level of rebate dollars, although the demonstration does not change the statutory provisions specifying the rebate levels for different star ratings.
- Under the statutory provisions that introduced quality bonus payments, only plans at 4 stars or above would have received bonuses. Under the demonstration, only about 8 percent of enrollees are in plans not receiving quality bonuses (2.5- and 2-star plans), whereas under the statutory provisions 72 percent of enrollees would have been in plans not receiving a quality bonus. (The quality bonuses for 2013 are based on 2012 star ratings. The 2013 star ratings were the ratings displayed during the October–December 2012 enrollment period.)
- HMOs are the only plan type for which there are 5-star plans. Eight MA HMO plans and three cost-reimbursed HMO plans have 5-star ratings. The highest star rating attained by any local PPO is 4.5, whereas the highest rating for a PFFS plan is 3.5 (for one plan). One regional PPO plan has a 4.5-star rating, but most regional plan enrollees (56 percent) are in plans with a 3-star rating.

Under the statutory bonus provisions, no PFFS plans would have received bonus payments, and only 2 percent of regional plan enrollment would be in bonus plans if 2013 stars were used to determine bonuses. For HMOs, 42 percent of enrollees would be in bonus plans and 36 percent of local PPO enrollment would be in such plans.

- The criteria for determining plan star ratings change from year to year. Therefore, plan ratings across years are not entirely comparable. Between 2011 and 2013, star rating criteria were changed and a weighting approach was used as of 2012. In 2013, 66 percent of the weight of measures reflects Part C and Part D clinical quality measures, compared with 62 percent in 2012 and 49 percent in 2011.

Web links. Medicare Advantage

- Chapter 13 of the Commission's March 2013 Report to the Congress provides information on Medicare Advantage plans.

http://www.medpac.gov/chapters/Mar13_Ch13.pdf

- More information on the Medicare Advantage program payment system can be found in the Commission's Medicare Payment Basics series.

http://www.medpac.gov/documents/MedPAC_Payment_Basics_12_MA.pdf

- CMS provides information on Medicare Advantage and other Medicare managed care plans.

<http://www.cms.gov/Medicare/Health-Plans/HealthPlansGenInfo/index.html>

<http://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/MCRAAdvPartDENrolData/index.html>

- CMS star ratings for Medicare Advantage plans can be found at

<http://www.cms.gov/Medicare/Prescription-Drug-Coverage/PrescriptionDrugCovGenIn/PerformanceData.html>

- The official Medicare website provides information on plans available in specific areas and the benefits they offer.

<http://www.medicare.gov/>